

SOUTH DAKOTA STATE BOARD OF PHARMACY

3701 W. 49th Street, Suite 204
Sioux Falls, SD 57106
605-362-2737
www.pharmacy.sd.gov

Application for Reinstatement as a Pharmacist in South Dakota

Name:

Last

First

Middle

Maiden

Mailing Address:

City/State/Zip:

Phone # (Please include area code)

Date of Birth:

South Dakota Pharmacist License Number

Social Security Number:

Last Year Licensed in South Dakota

Other states where you are licensed as a pharmacist (please include certificate number)

WORK HISTORY (begin with most current)

<i>DATES</i>	<i>PHARMACY</i>	<i>ADDRESS</i>	<i>PHONE</i>

The following must be furnished with application:

- Back fees for the years that you were not licensed in SD (maximum of 10 years) payable to the South Dakota Board of Pharmacy:

2001-2002	\$125	2006-2007	\$125
2002-2003	\$125	2007-2008	\$125
2003-2004	\$125	2008-2009	\$125
2004-2005	\$125	2009-2010	\$125
2005-2006	\$125	2010-2011	\$125
- Penalty fee (\$25) payable to the South Dakota Board of Pharmacy.
- 12 hours of continuing education completed within the last 24 months as indicated on the back of this form.
- You may also be required to successfully complete South Dakota's pharmacy jurisprudence examination.
- A copy of any current registered pharmacist licenses.

FOR SD BOP USE ONLY

Received _____ Check # _____ Amount _____ Approved _____ Issued _____

Continuing Education Form

South Dakota Board of Pharmacy Laws and Rules:

20:51:19:03. Hours required. To qualify for re-licensure, an active pharmacist must successfully complete 12 hours of continuing education. The 12 hours of continuing education required each year for re-licensure must be completed within the 24 months before the pharmacist's certificate of registration expires. When a pharmacist applies for yearly renewal of his certificate of registration pursuant to SDCL 36-11-23, he must report his completed continuing education hours on a form supplied by the board.

Summary of Continuing Education Hours (hours must have been completed within the preceding 24 months)			
Program Name	Program Location*	Program Date**	Hours Earned

*If correspondence, name publication or source

**If correspondence, date completed or date of certificate

Applicant's record of charges, convictions, and discipline:

Please answer the following questions. If you answer "yes" to any of the questions, please provide a complete description of dates and circumstances on a separate piece of paper. You must send supporting documents that are applicable.

1. Have you ever been convicted, pled guilty or no contest, or received a suspended imposition of sentence for a felony or other criminal offense (excluding minor traffic violations)? ____Yes ____No
2. Is there any pending criminal prosecution against you, which would constitute a felony? ____Yes ____No
3. Has your license or certification in any state or Canadian province been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action? ____Yes ____No
4. Are you presently being investigated or is disciplinary action pending against your license? ____Yes ____No
5. Within the last three years, have you been treated for abuse or misuse of any alcohol or chemical substance to the extent that your ability to practice as a pharmacist has been impaired? ____Yes ____No
6. Within the past three years, have you experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care? ____Yes ____No
7. Have you accumulated child support arrearages in the sum of one thousand dollars or more? ____Yes ____No

Affidavit: This section must be completed in the presence of a notary public.

I, the undersigned, being duly sworn, say that I am the person referred to in the foregoing application, and I declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Signature of Applicant_____

Subscribed and sworn to before me this ____ day of _____, 20____

NOTARY
SEAL

Signature of Notary Public_____

Notary for the State of _____ My commission expires_____